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Absorptive Capacity for Government and Donor Funding: *Assessing the DOH Case*

*Alexander Michael G. Palma**

There are many factors that affect the manner and extent over which available government and donor funding are utilized for programs and projects in a particular sector. In the social services sector such as health, these factors include the external environment conditions like institutional mechanisms and the prevailing demand for services as evidenced from morbidity and mortality rates.

Looking at the major public programs of the Department of Health (DOH), particularly the accomplishments in terms of cases treated and served, we can say that not only is the magnitude of financial resources important but also the timing of fund release and its accessibility from various sources.

As such, it is important that we are able to determine how a particular expenditure target for a particular budget year is met, as measured against the institutional process of budget release and the accomplishments of the agency for its various programs. In so doing, we will be able to see where the bottlenecks exist and how they can be resolved in order to bring about better delivery of health services.

In this light, this *Policy Notes* discusses various measures by which to assess the absorptive capacity of an agency—in this case, the DOH—for its available financial resources, sourced from the national government's annual budgetary allocations, including those from official development assistance.

Defining absorptive capacity

Absorptive capacity, as it relates to budget performance, is defined as the ability of an agency to maximize the use of available financial resources. In assessing the DOH's absorptive capacity, four measures or indices are being presented in this *Notes* (please refer to Box). These

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*The author is Managing Director of Asian Communication Edge (ACE), Phils.

Measures of absorptive capacity

Appropriation Utilization Index ($ApUI_y$) = Obligation/Appropriation

$ApUI_y$ indicates the agency's ability to utilize funds relative to the legislated/statutory spending target. In principle, the index takes on values that range from 0 to 1. At one end of the scale, an index = 1 would imply full achievement of the target. At the other end, an index = 0 would mean extremely poor performance. In practice, however, the index for a specific program (or agency) may exceed unity. This happens when specific items in the Government Appropriations Act (GAA) are realigned in favor of said program (or agency).

Budget Programming Index (BPI_y) = Allotment/Appropriation

This index basically shows the extent to which the legislated budget (appropriation) for the agency for the year has been prioritized by fiscal authorities, given the actual availability of funds from domestic and external sources. In comparison with the BPI of other agencies, this index indicates the relative importance given to the agency's programs, activities and projects (PAPs) by the Department of Budget Coordination Committee (DBCC) which acts through the Department of Budget and Management (DBM) in its programming of government funds.

Allotment Utilization Index (AUI_y) = Obligation/Allotment

AUI_y shows the extent to which an agency effectively utilizes the available resources at any given time. For instance, the Department of Health (DOH), despite of the inroads it made regarding reforms, still has to address a number of issues that could help improve its utilization rates especially with respect to foreign-assisted projects.

Overall Absorptive Capacity Index (OACIy) = AUI/BPI

This measures the congruence between an agency's ability to utilize the allotments received (AUI) and the relative priority given to the agency by the fiscal managers (BPI). OACIy exceeds unity if the allotment utilization rate is greater than the relative priority given to the agency by the DBM. An OACI > 1 suggests that the agency can still absorb more funds, if funds would have increased. Conversely, OACIy falls short of unity if the allotment utilization rate is lower than the relative priority given to the agency by the DBM. An OACIy < 1 indicates that the DBM programmed more funds for the agency than what it can absorb. On the other hand, an OACIy = 1 represents the happy middle that is achieved when budget programming matches the agency's capacity for fund absorption.

are: (a) appropriation utilization index, (b) budget programming index, (c) allotment utilization index, and (d) overall absorptive capacity index.

At the outset, however, it must be emphasized that these indices or utilization rates need to be examined vis-à-vis the physical accomplishment of a specific project at any given time. For unlike other outputs or services such as physical infrastructure, the accomplishments in health care delivery are not readily measurable. Thus, a favorable utilization rate (based on any one of the measures of absorptive capacity outlined in the Box) may not mean that there is a better attainment of the DOH's performance targets. Conversely, a lower utilization rate may have been due to a lower prioritization given to a particular health program as brought about by already decreasing mortality rates in previous periods.

It is therefore very critical to look into specific projects, the stage at which objectives are attained at a given time, and the conditions by which they were implemented. The next sections thus look into the DOH's budget performance by health program, absorptive capacity and program accomplishments.

Fund utilization by health program

How did the DOH utilize its funds in terms of program? Which program proved to have efficiently spent or used its financial resources? Below is an account by program.

Public health services. Budget programming index (BPI) fell from 84 percent in 1996 to 76 percent in 1997 due to a disproportional reduction in the allotment levels in 1997. Despite the low allotment, though, expenditure levels were high during this period, more particularly for

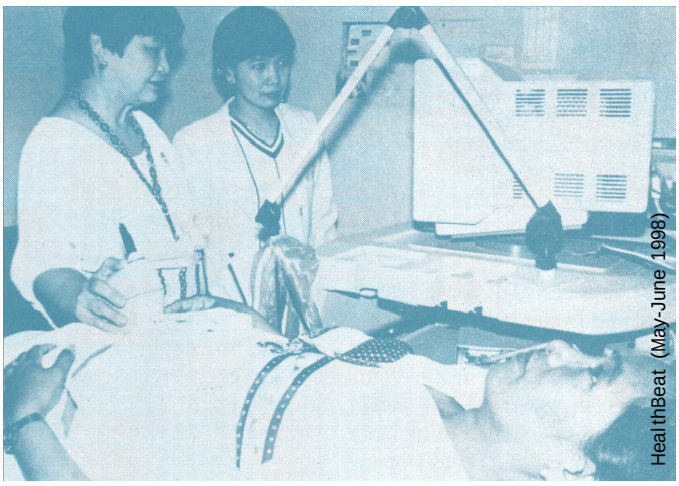
maternal and child health service. In 1998, the BPI grew to 92 percent as allotment rose from P960.8 million in 1997 to P1.2 billion. Despite full allotments given to programs such as diarrheal control, however, total amounts obligated from what has been alloted or the allotment utilization index (AUI) remained low. In the same manner, other noncommunicable control programs registered low AUIs. For communicable disease programs, it is interesting to see that the overall absorptive capacity index (OACI) results show that these programs have a greater capacity to absorb more alloted funds. The OACI only dropped in 1988 because there was a substantial drop in allotment levels. Expenditure comes closest to the given appropriation in 1997 when ApUI was closest to 1. Since expenditure levels, at least for other programs, have been low and allotment levels also plunged simultaneously, any increase in allotments must be geared towards public health services where expenditure levels are not only high but also efficient.

Hospitals and facilities services. Allotments increased by more than two-folds (33 to 81 percent) from 1996 to 1997. However, there was a slow increase in ApUI due to a big disparity of the allotment from given appropriation. In 1998, there were very substantial suballotments to the regions. During this period, allotment increased but expenditure did not grow proportionately. This situation was reversed in 1999 when allotments have been reduced, but expenditure recorded its highest, thus registering a high 98 percent AUI. This means that allotment for this year can be taken as an ideal level. High expenditure in this year resulted to significant accomplishments by hospitals, as reported.

Primary health care. BPI almost remained unchanged from 1996 to 1999, which means that the allotments and amount of appropriation were maintained. In terms of expenditure, however, there was a large increase causing AUI to fall because of the nonmovement in given allotments. In 1999, OACI was recorded at 1.33 indicating that the budget alloted was completely obligated.

Health facility standards, regulations and licensing. Budget for this program goes primarily to attached agencies and other operational units. There was a 60 percent drop in the program's budget in 1997 accompanied by a low level of release, explaining the low BPI rate of only 12 percent. The allotment in the preceding year was only 8 percent higher with an appropriation of P676.2 million. This was the highest given in the four-year period under review. A high OACI was registered for this program which is expected given the trends in allotment and level of spending, and a declining appropriation. It is also not surprising to see less than 10 percent ApUI for this budget item from 1996 to 1999 because allotments and obligations did not really grow as much despite the lowering of appropriations each year.

Management services. The GAA has categorized these services as support to operations. These services include health information and health education services, health human resource development system, health policy and development program, Department of Legislative and Executive Liaison and Coordination, National Drug Policy, Essential National Health Research, and Local Government Assistance and Monitoring Systems (LGAMS). In general, management services follow an upward trend in the appropriation levels, averaging at around P193.5 million. BPI rates were generally high (more than 90 percent) throughout 1996 to 1999, with the most favorable rates recorded for health



HealthBeat (May-June 1998)

human resource development system, health policy and development program, and the program under the Department of Legislative and Executive Liaison and Coordination. Actual spending levels approximated allotments, particularly in 1996 and 1998. In 1997, there was a slowdown in the utilization of allotment as AUIs went down for most activities, except for programs on the National Drug Policy, Essential National Health Research and LGAMS. OACI hovered around unity from 1996 to 1998, indicating success in matching budget programming with fund utilization capability for support to operations.

Projects. The level of budget releases indicates that much is to be desired for both locally-funded projects (LFPs) and foreign-assisted projects (FAPs). In 1996, only 56 percent of the appropriation for LFPs was actually released. This dropped further to 26 percent in 1997. In the case of FAPs, allotment was 25 percent of the appropriation in 1996 and declined the following year to 8 percent. The BPI rates have been poor despite the increase in appropriation for both types of projects. In terms of the allotment utilization rate, FAPs had a higher rate (92%) than LFPs (46%) in 1996. These significantly dropped to 26 percent and 28 percent, respectively, the following year. This indicates that the level of expenditures really deteriorated because the degree of increase in obligation did not grow as much as the increase in allotment. Low AUI rates for LFPs can be attributed to the termination of some activities because of derailed implementation. Among the reasons cited, the most significant was the inability to mobilize committed local government resources.

Regional budget. Decentralization paved the way for increased appropriation for the regions. The highest increases were posted at 26 percent and 19 percent in 1997 and 1998, respectively. However, actual budget releases increased at a slower rate starting in 1997, as reflected in the BPI values (Table 1). The AUI remained high but declined starting 1998, suggesting some deterioration in fund utilization of the regional offices. The delayed releases may partly explain why AUI decreased starting 1998 although admittedly, there were also implementation problems in the regional programs. The budget reduction equivalent to 25 percent as mandatory savings imposed in 1998 explains the decline in AUI rates after said year. This imposition, along with the incidence of delayed releases, compounded problems that have affected the utilization of budgetary resources. This is also evident in the high OACI in 1998 (1.226), indicating that the DOH actually had the capacity to absorb more funds for its programs and projects.

Absorptive capacities and accomplishments in health programs

An attempt to look at the results of the utilization of resources in DOH health programs, and then to correlate them to the level of program accomplishments was undertaken in an aim to use the indices as measures to validate whether the accomplishments are comparable to the level of resources and extent of their utilization (Table 2). The major findings are as follows:

- The trend of accomplishment in the delivery of prenatal and postpartum care follows the increases in absorptive capacity indices recorded from 1996 to 1997.

Table 1. Consolidated regional appropriations, allotments and obligations

Year	Appropriation	Allotment	Obligation	ApUI	OACI	AUI	BPI
1996	4,965,333,000	4,406,518,000	4,689,273,000	0.9444	1.1991	1.0642	0.8875
1997	6,277,198,000	5,229,204,000	6,790,184,978	1.0816	1.5588	1.2985	0.8330
1998	7,490,776,000	5,429,784,651	4,982,874,422	0.6652	1.2660	0.9177	0.7249
1999	7,915,538,000	6,260,736,078	5,320,787,187	0.6722	1.0745	0.8499	0.7909

Source: Table 4 of PIDS Discussion Paper Series No. 2001-04.

Table 2. Utilization measures and accomplishments of DOH health programs, 1996-1998
(In percent)

Health Programs	1996			1997			1998		
	OACI	AUI	% Accomplish.	OACI	AUI	% Accomplish.	OACI	AUI	% Accomplish.
1. Prenatal and Postpartum Care	**79**	**71**	56	**103**	**94**	69	**33**	**27**	59
- Pregnant women with three or more prenatal visits									
2. Fully Immunized Children	**52**	**41**	90	**100**	**89**	89	**25**	**22**	85
3. Control of Diarrheal Diseases	**4**	**4**	36	**0.5**	**0.5**	32	**0.7**	**0.7**	28
- Diarrhea cases given ORS									
4. Acute Respiratory Infection	**98**	**88**	68	**100**	**10**	64	**20**	**0.09**	52
- Pneumonia cases (0-59 mos) given treatment									
5. Nutrition	**118**	**100**		**114**	**96**		**66**	**56**	
- Food Supplementation among 6-59 month-old children			14			10			8
- Children (12-59 months) given Vitamin A			94			93			90
6. TB Control	**102**	**87**		**383**	**333**		**59**	**29**	
- Total TB cases			0.39			0.28			0.21
7. Leprosy Control Program	**87**	**67**	0.02	**161**	**58**	0.02	**52**	**13**	0.02
- Prevalence rate									
8. Filariasis Control Program	**123**	**90**	45	**122**	**94**	68	**111**	**72**	29
- No. of filaria cases given treatment									
9. Malaria Control Program	**66**	**57**		**108**	**94**		**80**	**70**	
- No. of continued cases			0.08			0.09			0.09
- No. of clinically-diagnosed given treatment			41			88			51
10. Sexually-Transmitted Diseases	**300**	**99**		**135**	**97**		**100**	**58**	
- No. of women with vaginal discharge			12			0.16			0.12
- No. of menstruation and urethral discharge			0.03			0.03			0.02
- No. of men/women with genital ulcers			0.01			0.003			0.001
11. Environmental Health Program	**117**	**84**		**141**	**97**		**95**	**72**	

Source: Annex 5 of PIDS Discussion Paper Series No. 2001-04.

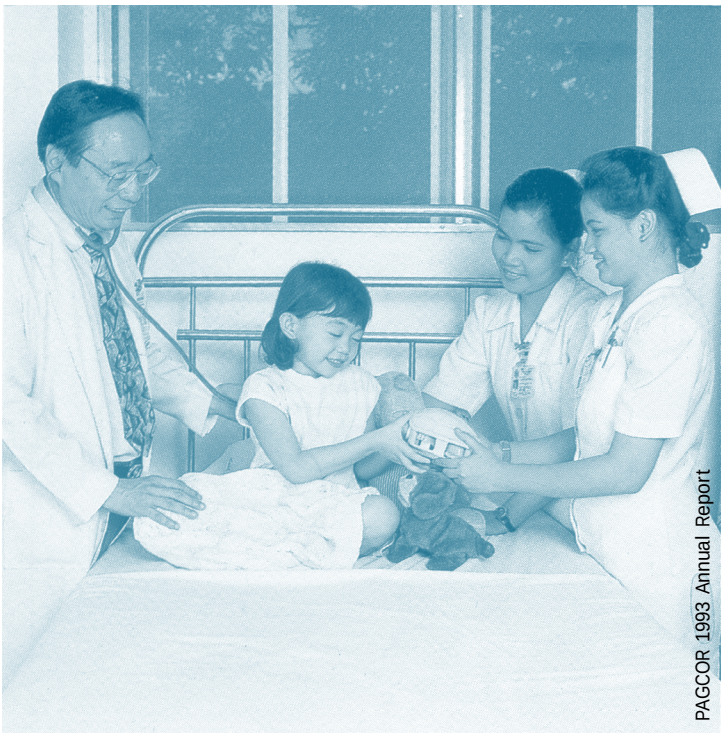
Alongside with the recorded increases in allotment and obligations, accomplishment also grew from 56 percent to 69 percent. This is in terms of the population that received prenatal care and use of public health facilities.

❊ Despite a marked increase in the AUI from 41 percent in 1996 to 89 percent in 1997, a slight dip in the record of accomplishment in the said period (from 90% to 89%) for the expanded immunization program was recorded. Unlike the prenatal and postpartum care, there seems to be very little effect of the financial utilization to the delivery of services here to actual number of people. This may be attributed to the many problems encountered in the distribution of vaccines such as the geographical distance and the lack of commitments of some LGUs to shoulder accompanying expenses.

❊ Given the substantial number of the affected segment of the population with diarrheal diseases and the relatively lower level of accomplishment and AUI rates, it can be generalized that the number of delivered services in this program are influenced by utilization rates.

❊ It was observed that the AUI for acute respiratory infection declined drastically from 1996 to 1998. The decline meant very low expenditure levels for said cases. In terms of accomplishments, meanwhile, of the positively identified population of children 0-59 months with pneumonia, 68 percent were given treatment in 1996, 64 percent in 1997 and 52 percent in 1998. It appears then that even as accomplishments have declined, the level was not as much as the downturn in AUI.

❊ In the case of the nutrition program, high AUI rates were accompanied by lower rates of accomplishment, except for the program component catering to children (12-59 months) given Vitamin A.



PAGCOR 1993 Annual Report

❊ The cost of diagnosis and treatment of tuberculosis to a substantial number of affected population could explain why utilization ratios were high. Accomplishment, however, remained low. The trend in accomplishments follows utilization (by magnitude) just like in the case of the immunization program. Unlike the other programs, though, its large population base will expectedly make the level of accomplishment low.

❊ The low accomplishment rate in leprosy control of .02 percent over the three-year period is attributable to its large target base. In 1996 and 1997, AUI was recorded at 67 percent and 58 percent, respectively, and experienced a rapid downturn to 13 percent in 1998. The dismal performance in 1998 may have been partly due to the very small percentage of appropriation (25%) released.

❊ Filariasis control program is another typical case where the rate of accomplishment increases with the improvement in AUI. Improvement in the delivery of services from 45 percent to 68 percent in 1996 and 1997, respectively, was accompanied by a growth in AUI from 90 to 94 percent. The decline in allotment in 1998 was accompanied by a slowdown in expenditures, resulting in a high AUI rate.

❊ The number of malaria cases given clinical diagnosis and those given treatment increased from 41 in 1996 to 88 percent in 1997. AUI in said years have also risen from 57 to 94 percent. Despite the lowering of allotment in 1997, expenditure further improved from the preceding year resulting to high AUI.

❊ Like the Tuberculosis Control Program, accomplishment rates in the control of sexually-transmitted diseases have been rather constant and low because of the large target population base. Although AUIs were particularly high in 1996 (99%) and 1997 (97%), a marked decline in diagnosed cases was reported.

❊ The Environmental Health Program is geared at

providing households access to safe water supply, sanitary toilets, satisfactory garbage disposal, and other sanitation facilities. AUI was highest in 1997 (97%) but slightly dropped to 72 percent the following year. Accomplishments, however, generally improved. The drop in AUI in 1998 was brought about by the increased allotment but expenditures did not respond in a similar manner.

Issues and future organizational concerns

Given the above results showing fund utilization patterns vis-à-vis actual accomplishments, the following concerns may be raised.

Procurement issues. One of the major concerns believed to have hindered the required expenditure level at a given schedule is the slow pace in the procurement of medical goods and services. This holds true not only for the regular DOH programs but also for locally-funded and foreign-assisted projects as well. Needless to say, failure to expend in a timely manner affects the delivery of medical goods and services to the beneficiaries. This is probably why we see high values of OACI and lower accomplishment rates.

Complications in functional deconcentration / devolution. The re-engineering of the DOH finds its basis from the current thrust to devolve operations to the regions, enhance the disease control and health facilities development program, and increase the scope and access to health financing. Given these new directions, the devolved set-up is expected to present some complications.

Budget releases and monitoring. In the aspect of financial management, only recently was the central office required to consolidate expenditures of hospitals and other health facilities in the regions. Some of these hospitals and health facilities receive direct releases while others receive their allocations through the regional health offices (RHOs). This directive to the central office by the Commission on Audit compelled the regional health offices to align financial reporting of hospitals and health institutions with the accepted standards prescribed. While at present this practice poses no problem, the autonomy in operations of these hospitals and health institutions makes it at times difficult for RHOs to request for the financial information, especially from those receiving direct releases.

LGU commitment and participation. The Local Government Code of 1991 failed to integrate the promotional, preventive, curative and rehabilitative services that the health sector is expected to deliver. Thus, the Health Sector Reform Agenda is set to introduce changes in health service delivery, health regulations and health financing that would help alter the experiences in the past.

Cost overruns. Like all other foreign-assisted projects, the gestation period involved before a project is implemented results in the need for some revisions in the original cost estimations. These cost overruns further cause the delay in the release of funds since requests for revised cost estimates are dealt with caution by the approving bodies.

Recommendations

In response to some of the above issues raised, a number of recommendations are hereby forwarded.

- ***Addressing procurement delays***. The central office should further examine the most suitable procurement procedure with due consideration to price, quality, efficiency in delivery and the segmented demand from the different regions. The guidelines governing the combined method of centralized bidding and regional procurement and distribution need to be reviewed and strengthened.

- ***Affirmation of LGU resource commitment***. Assurance of commitment from the LGUs may involve a strategy that can be rooted from project planning stages. The DOH, as a clearinghouse for proposed projects, should conduct consultations and institutionalize project management processes together with the LGUs.

- ***Institutional alignment in healthcare monitoring***. Both national and local agencies have to be aligned

institutionally. For example, LGUs' participation in compelling hospitals under their jurisdiction to work closely with rural health offices under a well-placed monitoring system is extremely crucial to make available reports generated at the regional level.

❊ ***Consolidation of monitoring efforts in project implementation of foreign-assisted projects***. External to DOH are measures that will help strengthen the agency's internal monitoring system. This includes the incorporation of the task of "results monitoring and evaluation" in the approval process of the Investment Coordination Committee (ICC). Within DOH, there are also plans to unify several Project Management Offices under one group.

For further information, please contact

The Research Information Staff
Philippine Institute for Development Studies
NEDA sa Makati Building, 106 Amorsolo Street
Legaspi Village, Makati City
Telephone Nos: 8924059 and 8935705;
Fax Nos: 8939589 and 8161091
E-mail: mgpalma@hotmail.com
jliguton@pidsnet.pids.gov.ph

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